

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN9007</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/19/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>JOHN M REED NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>124 JOHN REED HOME RD</b> <b>LIMESTONE, TN 37681</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	<p>Initial Comments</p> <p>During a complaint investigation at John M. Reed Nursing Home on July 19, 2012, no deficiencies were cited under 1200-8-6, Standards for Nursing Homes.</p> <p>C/O: #30083</p>	N 000			

Division of Health Care Facilities

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1